

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03485
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

Anne Arundel

City or town.....

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11 Toney Avenue

How long in hospital or institution?

3. (a) FULL NAME

Samuel Tilden Atwell

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

Married

6.(b) Name of husband or wife

Anna M. Atwell

7. Birth date of deceased (mo. day, yr.)

6.(c) If alive, give age.....years

July 9th 1876

8. AGE:

Years

Months

Days

If less than one day

71

9

3

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

Robert T. Atwell

A. A. Co. Md.

13. Birthplace

Minic Firehouse

14. Maiden name

A. A. Co. Md.

15. Birthplace

A. A. Co. Md.

16. Informant

Mrs. S. T. Atwell

Address

Annapolis, Md.

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Md.

18. Funeral director

John W. Taylo

Address

Annapolis, Md.

19. April 14, 1948

Date rec'd by registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County A. A. Co.

City or town.....

Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.

11 Toney Ave. (If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Apr 12 1948 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

our 19.41 to Apr 12 1948

and that I last saw him alive on Apr 12 1948

Immediate cause of death.....

Economy of respiration

Due to: Anterior cerebral aneurysm

was near his case

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

S. Bowersuch M.D.

4/13/48

RECEIVED
APR 15 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03487
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 50 years

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?..... 1/2 hours

3. (a) FULL NAME

Edward A. Bates

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife..... Annie L. Bates

7. Birth date of deceased (mo., day, yr.)

July 12, 1897

6. (c) If alive, give age..... 58 years

8. AGE: Years

50

Months

9

Days

1

If less than one day

hrs.

min.

9. Birthplace..... Indiana

(Town, county, and state)

10. Usual occupation..... Locksmith

11. Industry or business

MOTHER FATHER

12. Name..... Henry H. Bates

13. Birthplace..... Indiana

14. Maiden name..... Willie Mae Cushing

15. Birthplace..... Pa

16. Informant..... Mrs. Annie L. Bates

Address..... R.F.D. 1 Annapolis, Md

17. Burial..... Burial

(Burial, cremation, or removal. Which?)

Date thereof..... April 16/48

(month) (day) (year)

Cemetery or crematory..... Arlington

Location..... Arlington, Va.

18. Funeral director..... 135 & 24 Arlington Rd

Address..... Annapolis, Md.

April 15 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Anne Arundel

City or town..... Rural - Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.F.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

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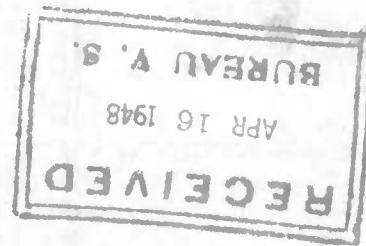
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03488

CERTIFICATE OF DEATH

83a
80
Reg. Dist. No. 28

1. PLACE OF DEATH:

Anne Arundel County

County

Crownsville, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 months

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital/institution?

7 months

3. (a) FULL NAME

EVA BATSON

4. Sex

Female

5. Color or race

Black

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

?

7. Birth date of deceased (mo., day, yr.)

1876

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

Laundrist

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

?

13. Birthplace

?

14. Maiden name

?

15. Birthplace

?

16. Informant

Hospital records

Address

Crownsville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 14 1948
(month) (day) (year)

Cemetery or crematory

I Mt. Auburn Cem.

Location

Mt. Auburn

18. Funeral director

Mrs. Margaret J. Hensley

Address

578 W. Bidwell St.

19. Date rec'd by registrar

4/14/48

KS

E. Joyce Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 556 Orchard Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 9 1948 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 1947 to April 9, 1948

and that I last saw her alive on

Immediate cause of death

Cerebrovascular accident

Due to Hypertension

Due to

Other conditions Emaciated

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

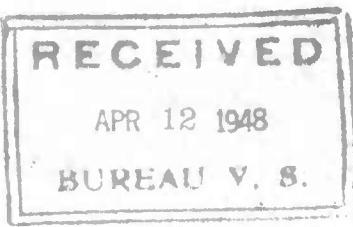
Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed



03489

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

144a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County: Annapolis
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 hrs. 15 min.
 Hospital, institution, or street address where death occurred: Johnsons' Clinic — 40 Northwest Street
 How long in hospital or institution? 11 hrs. 15 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Anne Arundel
 City or town: Shady Side
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: Shady Side, Maryland
 (If rural, give LOCATION)

3. (a) FULL NAME Ida Dennis Blunt
 4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Edward Blunt
 7. Birth date of deceased (mo., day, yr.) March 22, 1931 6. (c) If alive, give age years
 8. AGE: Years Months Days If less than one day 17 1 8 hrs. min.
 9. Birthplace Shady Side, Anne Arundel Co. Md. (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business None
 MOTHER FATHER
 12. Name Julius Dennis
 13. Birthplace Shady Side Anne Arundel Co. Md.
 14. Maiden name Lillian Dennis Johnson
 15. Birthplace Shady Side, Anne Arundel Co. Md.
 16. Informant Julius Dennis
 Address Shady Side Anne Arundel Co. Md.
 17. Burial Date thereof May 3, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Matthews Cemetery
 Location Shady Side Anne Arundel Co. Md.
 18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street
 19. (Date rec'd by registrar) May 3 1948
 (Date signed) *[Signature]*
 VS A15 9-45-15M
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1948, to April 30, 1948, and that I last saw her alive on April 30, 1948.

Immediate cause of death Eclampsia DURATION 13 hrs.

Due to Pregnancy - 9 mo. Twins

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

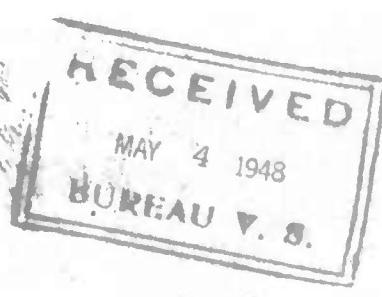
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Hedene V. Johnson, M.D.*

M. D. or other

Address 40 Northwest Street Date signed 5/3/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Unimportant items may be omitted. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03490

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town ANNAPOLIS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

Gladys T. Boush

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

J. CARSON Boush

7. Birth date of deceased (mo., day, yr.)

DECEMBER 17, 1892

6. (c) If alive, give age years

8. AGE:

Years
65Months
4Days
12

Less than one day

hrs.
.....min.
.....

9. Birthplace

(Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

-

MOTHER FATHER

12. Name OLIVER LEAGUE13. Birthplace WINCHESTER, Virginia14. Maiden name Ida M. Fauche15. Birthplace LEESBURG, Virginia16. Informant MRS. EDWARD L. TRADERAddress W. ANNAPOLIS, MD.17. Burial BURIAL Date thereof 5/1/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CEDAR Bluff CemeteryLocation ANNAPOLIS, MD.18. Funeral director JOHN M. TAYLOR SONAddress ANNAPOLIS, MD.19. Date rec'd by registrar May 1, 1948
(Date rec'd by registrar) John Finch
Signature John Finch
Address ANNAPOLIS, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.County P. A. Co.City or town WEST ANNAPOLIS

(If outside city or town limits, write RURAL and give nearest town)

Street No. SEVERN AVENUE

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH april 29, 1948 at 8:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from april 4, 1948 to april 29, 1948 and that I last saw her alive on 4-29 1948

Immediate cause of death

Coronary Thrombosis

DURATION

4 daysDue to Hypertensive Cardio-
vascular disease

DURATION

3 yrs.Due to Arteriosclerosis, generalized5 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE James R. Master, M.D. M. D. or otherAddress ANNAPOLIS, MD. Date signed 4/30/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.



03491

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diet. No. 21

1. PLACE OF DEATH: Anne Arundel
County.....
St. Margarets

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Giselle Bowdoin

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced
Married

6.(b) Name of husband or wife James S.

7. Birth date of deceased (mo., day, yr.) Sept 23, 1871 6.(c) If alive, give age 78 years

8. AGE: Years 76 Months 6 Days 18 If less than one day hrs. min.

9. Birthplace Vienna, Austria (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name..... Norbert deCramer
13. Birthplace Smyra, Turkey
14. Maiden name..... Lucy Wood

15. Birthplace Smyrna, Turkey
James S. Bowdoin

16. Informant.....
Address St. Margarets, Md.

17. Burial Date thereof 4/13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D. C.

18. Funeral director T.A. Hardesty & Son
Address Galesville, Md.

19. April 13, 1948
(Date rec'd by registrar) *W. - D. much*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Md. County..... A.A.

City or town..... St. Margarets

(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948 at 8²⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 19. 44 to Apr. 10 1948
and that I last saw her alive on Apr. 10 1948

Immediate cause of death arteriosclerotic cardiovascular disease
DURATION 15 yrs.

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

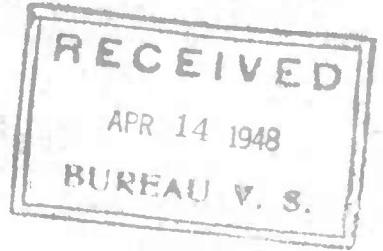
Means of injury..... Injured at work?

23. SIGNATURE S. Bowdoin M.D.

M. D. or other

Date signed 4/13/48

Address Annapolis, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462
03492

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
AT RESIDENCE

How long in hospital or institution?

3. (a) FULL NAME

Agnes Buys

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife HENRY A. Buys7. Birth date of deceased (mo. day, yr.) APRIL 15 18848. AGE: Years 64 Months 0 Days 35 It less than one day hrs. min.9. Birthplace SCOTLAND
(Town, county, and state)10. Usual occupation NONE11. Industry or business -12. Name JAMES MUNDELL13. Birthplace SCOTLAND14. Maiden name ISABELLA PROVEN15. Birthplace SCOTLAND16. Informant Mrs. HENRY A. BuysAddress Annapolis, Md.17. Cremation Date thereof 4/28/48
(Burial, cremation, or removal. Which?)Cemetery or crematory FT. LINCOLN CEMETORYLocation PRINCE GEO. COUNTY - MD.18. Funeral director John M. Taylor & SonAddress Annapolis, Md.19. April 28, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.City or town ANNAPOULIS
(If outside city or town limits, write RURAL and give nearest town)Street No. 13 MCKENDEE AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Apr. 194821. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-10 1946 to 4-24 1948and that I last saw her alive on 4-23-48 1948

Immediate cause of death

Carcinoma, primary
in Sigmoid.

Due to

Colon Tumor

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

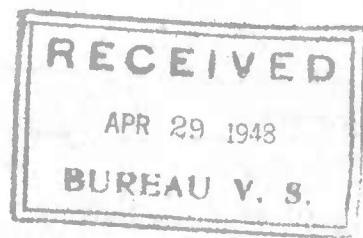
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.W. Miller, M.D. D. or otherAddress D. S. Naval Hospital Date signed 4-26-48

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03493

28

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Anne Arundel
 County.....
 Crownsville
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 2 mos.
 Hospital, institution, or street address where death occurred:
 Crownsville State Hospital
 How long in hospital or institution? 1 yr. 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Dorchester
 City or town..... East Newmarket
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

JOHN EDWARD DEMBY

3. (b) Social Security Number

4. Sex male	5. Color or race negro	6.(a) Single, married, widowed, or divorced divorced
----------------	---------------------------	---

6.(b) Name of husband or wife..... none

7. Birth date of deceased (mo. day, yr.) 1891

8. AGE: Years 57 Months Days If less than one day hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... none

MOTHER FATHER
 12. Name..... John H Demby
 13. Birthplace..... Dorchester County, Md.

14. Maiden name..... Cora Jackson

15. Birthplace..... Dorchester County, Md.

16. Informant..... Hospital Records
 Address..... Crownsville, Md.17. Burial..... Date thereof 4/19/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... East Newmarket

Location..... East Newmarket, Md.

18. Funeral director..... J. J. Frampton and Son
 Address..... Federalsburg, Md.19. April 15 1948
 (Date rec'd by registrar) E. Joyce Lorne
 Registrar**MEDICAL CERTIFICATION**

20. DATE OF DEATH..... April 13 1948 at 11:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 1948 to April 13 1948

and that I last saw him alive on April 13 1948

Immediate cause of death..... Cerebral Haemorrhage

DURATION.....

Due to.....

Due to..... Known to us since 2/19/47

Other conditions..... Psychosis with Cerebral
 Arteriosclerosis due to Hypertension
 and alcohol (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Jacob Manchester, M.D. M. D. or other

Address..... Crownsville, Md. Date signed 4/13/48

RECEIVED
APR 20 1948
BUREAU V. S.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
and birth date shown on:

2411 N. Charles St., Baltimore

PC
03494

File No. G 115 APR 29 1948

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH:

Anne Arundel
County: Crownsville
City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? October 27 - 41

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 years 5 months, 21 days

3. (a) FULL NAME

Robert Dickens

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

colored

married

6. (b) Name of husband or wife

Theresa Dickens

7. Birth date of

deceased (mo. day, yr.)

1885 ? 1875

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73 72 ?

—

—

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Laborer ?

11. Industry or business

12. Name

Robert Ray ?

13. Birthplace

14. Maiden name

Fannie Covenant ?

15. Birthplace

16. Informant

Hospital Records

Address

Crownsville Md.

Burial

Date thereof

(Burial, cremation, or removal. Which?)

4/20/48 (month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

a. Halstead

18. Funeral director

Address

918-18th & Hill

19. (Date rec'd by registrar)

4/20 1948

Registrar

John H. Keane

Signature

Address

20. (For newborn infants give residence of mother)

State

Maryland

County

Baltimore City

City or town

(If outside city or town limit, write RURAL and give nearest town)

Street No.

926 Dundalk Ave

(If rural, give LOCATION)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore City

City or town

(If outside city or town limit, write RURAL and give nearest town)

Street No.

926 Dundalk Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 17 1948

1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 27 - 41

1948

to February 17 - 48

1948

and that I last saw him alive on Feb 17 - 48

1948

Immediate cause of death

Arrakis myocarditis

gen. arteriopclerosis

Due to

Known

causes

since

41

DURATION

Due to

Other conditions

Family psychosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

POLYCHILO

PLEASE WRITE PLAINLY, WITH INK.
WITH INKADING INK. Supply every item of information carefully.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03495
94a
21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County... Anne Arundel

City or town... Marley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.... 7 Months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

LOTTIE DOUGLASS

4. Sex F	5. Color or race C	6.(a) Single, married, widowed, or divorced Married
----------	--------------------	---

6.(b) Name of husband or wife Joseph

7. Birth date of deceased (mo. day. yr.) July 4th 1898
6.(c) If alive, give age 51 years

8. AGE: Years	Months	Days	If less than one day
49	9	19	hrs. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Rastus Wilson

13. Birthplace Va.

14. Maiden name Sallie Scarboro

15. Birthplace Va.

16. Informant Sallie Wilson (Mother)

Address 242 Pine St., Balto. Md.

17. Burial Date thereof 4/27/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location A.A. County, Md

18. Funeral director Charles G. Cooper

Address 570-127 Carrollton Ave.

19. 4/26 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Ann Arundel

City or town Marley
(If outside city or town limits, write RURAL and give nearest town)

Street No. Marley Neck Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war No.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 1948 at 19.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw h. alive on 19..... to 19.....

Immediate cause of death Coronary occlusion

DURATION

Sudden

Due to Hypertension

3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

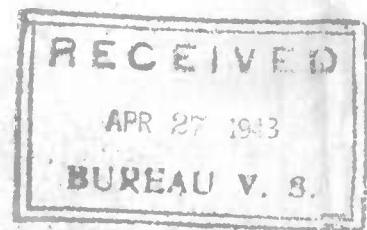
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave H. Pocheard
acting Deputy Medical Examiner
Address 1315 Bussell, Baltimore Date signed 4/26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

H66

03496

Reg. Diat. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town. Parole, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 Years
 Hospital, institution, or street address where death occurred:
 Parole Street Parole, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town. Parole, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Parole St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME
 Richard William Allen Embry

4. Sex Male	5. Color or race Colored	6.(a) Single, married, widowed, or divorced Married
-------------	--------------------------	---

6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo. day, yr.) January 4, 1894
 8. AGE: Years Months Days If less than one day

54	2	29	hrs.	min.
----	---	----	------	------

Philadelphia, Pa.
 (Town, county, and state)

9. Birthplace.....
 10. Usual occupation Cook
 11. Industry or business None

MOTHER FATHER
 12. Name James Crawford Embry

MOTHER
 13. Birthplace Indiana
 14. Maiden name Anne Elizabeth Johnson

15. Birthplace Annapolis, Maryland

16. Informant Louvina Marion Embry
 Address Parole St. Parole, Md. near Annapolis

17. Burial Date thereof April 6, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's Cemetery
 Location Northwest Street - Annapolis, Md.

18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. April 5, 1948 - D. Finch
 (Date rec'd by registrar)

3. (b) Social Security Number
 None

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2nd 1948 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16, 1948 to April 2, 1948 and that I last saw him alive on April 2, 1948.

Immediate cause of death
 Carcinoma of Stomach

DURATION
 2 years

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE
 A. P. F. Richard J. Finch
 M. D. or other

Date signed 4/5/48

Address

RECEIVED
APR 6 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03497

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County *A.A. Co.*City or town *Ferndale*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Andrew M. Tullius Sr.

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

W.

6.(b) Name of husband or wife

Clara

7. Birth date of deceased (mo., day, yr.)

June 10-1867

6.(c) If alive, give age years

8. AGE:

Years
*80*Months
*10*Days
4

If less than one day

hrs.
min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Attorney

MOTHER FATHER

12. Name

W

13. Birthplace

W

14. Maiden name

W

15. Birthplace

W

16. Informant

Andrew M. Tullius Jr

Address

24 Ferndale Ave. Ferndale

Burial

Date thereof: 4/17/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Glen Haven

Location

Pitcher Highway A.A.C.

18. Funeral director

Wm Cook Jr.

Address

1217 St Paul St.

19. Date reg'd by registrar

4/16/48

Date reg'd by registrar

A.W. Redick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*

County

*A.A. Co.*City or town *Ferndale Ave*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *24 Ferndale Ave*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Apr. 14. 48

19

10 AM

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

*March 8 1948 to April 14 1948*and that I last saw him alive on *April 14 1948*

Immediate cause of death

Cardio-Vascular Disease

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Chas. A. Baedke

M. D. or other

Address

Rutherford

Date signed

Apr. 14. 48

M

I

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

I PLEASE WRITE PLAINLY, WITH INKADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03498
138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 64 years

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?..... 4 days

3. (a) FULL NAME

Guy Gable (Guy Gable)

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Ella J. Gable

7. Birth date of deceased (mo., day, yr.)

Sept. 20, 1883

6. (c) If alive, give age..... years

8. AGE: Years

64

Months

6

Days

25

It less than one day

hrs.

min.

9. Birthplace

Annapolis, Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Rail Road

MOTHER FATHER

12. Name..... Chrestian V. Gable

13. Birthplace..... Annapolis, Md.

14. Maiden name..... Alice King

15. Birthplace..... Annapolis, Maryland

16. Informant..... Mr. Walter G. Gable (Son)

Address..... 2718 Ellicott Drive Baltimore 16, Md.

17. Burial..... Date thereof..... 4-19-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Anne's Cemetery

Location..... Annapolis, Maryland

18. Funeral director..... Ben L. Hopping and Son

Address..... 170-172 west St. Annapolis, Md.

19. April 19, 1948
(Date rec'd by registrar)J. P. French
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Rural - Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.F.D. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Aprt. 15 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aprt. 16 1948 to Aprt. 15 1948

and that I last saw h. in alive on Aprt. 15 1948

Immediate cause of death.....

Cardiorespiratory failure

Due to.....

Coronary sclerosis

Due to.....

Other conditions..... Pulmonary tuberculosis 4 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... E. Peyton Ritchie, M.D.

M. D. or other

Address..... Annapolis, Md. Date signed..... Aprt. 16, 1948



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

03499
31

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Anne Arundel
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 days.

Hospital, institution, or street address where death occurred:

Emergency Hospital - Baltimore,
Anne Arundel Co., Md.

How long in hospital or institution?.....

5 days

3. (a) FULL NAME

Gleiser, Mrs. Emma M.

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Louis Gleiser

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

July 26, 1885

8. AGE:

Years
61Months
8Days
26Days
less than one day

hrs. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

MOTHER FATHER

12. Name Gleiser

England

13. Birthplace

Elizabeth Battise

14. Maiden name

Elizabeth Battise

England

15. Birthplace

England

England

16. Informant

Louis Gleiser

England

17. Cemetery or crematory

London

England

Date thereof

April 28, 1948

(month) (day) (year)

Location

Baltimore

England

18. Funeral director

A. Karmel Evans

England

Address

1408 St. Charles St.

Date rec'd by registrar

4/26

19. Date rec'd by registrar

1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Anne Arundel

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Robinson P.O. at Co. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

No.

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 28, 1948, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 17, 1948, to April 24, 1948,

and that I last saw her alive on April 24, 1948.

Immediate cause of death

Cardiac Asthma

Due to

Antromodesta C. V. died

Due to

Other conditions

Diabetes Mellitus; old. Central Thrombs.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. J. Klawans, MD

M. D. or other

Address..... Baltimore, Md. Date signed..... 4/28/48

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town) 17 days
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred: Crownsville State Hospital
 17 days
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 810 West Mulberry St.
 (If rural, give LOCATION) ---

2.(a) If veteran, name war.

3. (a) FULL NAME
 JOSEPH GRAHAM

3. (b) Social Security Number

4. Sex male	5. Color or race negro	6.(a) Single, married, widowed, or divorced married
----------------	---------------------------	--

6.(b) Name of husband or wife..... Celia Graham

7. Birth date of deceased (mo., day, yr.) March 3, 1900

8. AGE: Years 48	Months 1	Days 6	It less than one day hrs. min.
---------------------	-------------	-----------	---

9. Birthplace..... Lena, South Carolina
 (Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business.....

MOTHER FATHER
 12. Name..... Thomas Graham
 13. Birthplace..... South Carolina

14. Maiden name..... Rebecca Brooks
 15. Birthplace..... South Carolina

16. Intermittant..... Hospital Records
 Address..... Crownsville, Md.

17. Burial..... Date thereof..... 4-13-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Mt. Auburn Cem.

Location.....
 18. Funeral director..... Katie R. Williams
 Address..... 322 W. Schroeder St.

19. Date rec'd by registrar..... 4-20-48
 (Date rec'd by registrar) *D. D. G.*
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 19 19 48 a 2:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 48 to April 19 19 48 and that I last saw him alive on April 19 19 48

Immediate cause of death..... General Paresis known to us since 4/2/48
 DURATION

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... --- Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. --- Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....
 injured at work?

23. SIGNATURE..... *Wesley Mayes*, M.D.
 M. D. or other

Date signed..... 4/19/48

Address.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03501

CERTIFICATE OF DEATH

1952
CB
Reg. Dist. No. 22

1. PLACE OF DEATH:

Anne Arundel

County

rural (Laurel)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo

Hospital, Institution, or street address where death occurred:

District Training School

How long in hospital or institution? 1 mo

3. (a) FULL NAME

CHARLES GREEN

4. Sex

M

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Apr. 24 1943

6. (c) If alive, give age years

8. AGE:

Years 4

Months 11

Days 25

If less than one day

hrs.

min.

9. Birthplace

Columbia, South Carolina

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

Charles Lee Green

13. Birthplace

Raleigh, North Carolina

MOTHER

14. Maiden name

Olivia Williams

15. Birthplace

Greenwood, South Carolina

16. Informant

D.T.S. records

Address

Laurel, Md

17. Removal

Date thereof: Apr. 19 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Washington

Location

10 b

18. Funeral director

Jesse S. Rhodes & Co.

Address

901-3rd St. S.W. Wash. D.C.

April 19, 1948

(Date rec'd by registrar)

Oliver Karslup

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

617 M. St. S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19, 1948, to April 19, 1948,

and that I last saw him alive on April 19, 1948.

Immediate cause of death

Pneumonia (hypostatic)

DURATION

Apr. 17, 1948

Due to

Due to

Other conditions Birth injury - spastic quadri-

plegia, edema, aspiration

Birth

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

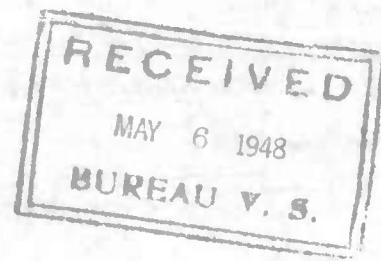
Injured at work?

23. SIGNATURE

J.A. Stoton, M.D.

M. D. or other

Address: District Training School, Laurel, April 19, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03502

30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
County.....
Bristol

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 60 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Frances Griffith

4. Sex F	5. Color or race C	6.(a) Single, married, widowed, or divorced Single
----------	--------------------	---

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Unknown 1864
(c) If alive, give age..... years

8. AGE: Years: Months Days If less than one day
84 . . . hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business Richard Griffith

FATHER 12. Name..... Md.

MOTHER 13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant Bernard Hardesty
Galesville, Md.

Address.....

Burial 17. (Burial, cremation, or removal. Which?) Moses Date thereof..... 4/3/48

Cemetery or crematory..... Drury, Md.

Location.....

18. Funeral director T. A. Hardesty & Son

Address..... Galesville, Md.

19. 4/3/48 19.....

(Date rec'd by registrar) M. or other

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Bristol
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1948 at 4:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1948, to April 1, 1948, and that I last saw her alive on March 31, 1948.

Immediate cause of death: Congestive Heart Failure
Due to: Arteriosclerosis DURATION 4 years

Due to: Nephritis DURATION 9 months

Other conditions: Secondary Arthritis DURATION 2 years

(Include pregnancy within 3 months of death)

Major findings or operations: none Date of op. _____

Autopsy results: No PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

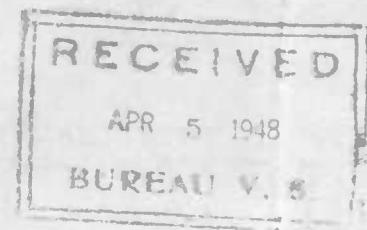
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James B. Farcer M.D. M. or other

Address: Upper Marlboro, Md. Date signed 4-2-48

Registrar





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45+

03563

23

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

A.A. CO.

City or town.....

GLEN BURNIE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

32 yrs

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

HENRY HERBERT HAGEDORN S.R.

3. (b) Social Security Number

YES

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

M

6.(b) Name of husband or wife.....

MARIE ANNA

7. Birth date of deceased (mo. day, yr.)

NOV. 4, 1897

6.(c) If alive, give age..... years

8. AGE:

Years
60Months
5Days
4

If less than one day

hrs.

min.

9. Birthplace.....

BALTO.

(Town, county, and state)

10. Usual occupation.....

J.W.T. CONSTRUCTION

11. Industry or business

JOHN

MOTHER FATHER

12. Name.....

JOHN

13. Birthplace.....

BALTO; MD.

MOTHER FATHER

14. Maiden name.....

LOUISE

15. Birthplace.....

GERMANY

16. Informant.....

MR. MARIE HAGEDORN (wife)

Address.....

313 BALTO Annapolis BLVD.

17. BURIAL

Date thereof.....

4/12/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

Woodlawn Cemetery

Baltimore Co. Maryland

18. Funeral director.....

W.M. T. TICKNER & SONS INC

Address.....

BALTO. MD.

19. 4-10

Date rec'd by registrar.....

1948

Autobranch

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MD.

County.....

A.A. CO.

City or town.....

GLEN BURNIE

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

313 BALTO

Annapolis BLVD

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

MEDICAL CERTIFICATION

20. DATE OF DEATH

4/8

19

48

al

10

AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1,

1948

to

April 8

1948

and that I last saw him alive on

April 7

1948

1948

Immediate cause of death.....

canceroma of the Lung

DURATION

6 months

Due to.....

canceroma of the Throat

18 months

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

John S. Bellingshousen M.D.

M. D. or other

Address.....

Ellen Barnes, MD

Date signed

April 9, 1948

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I
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The percentage
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

03509

Reg. Dist. No. 2

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Brooksville, P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rock Point Road.

How long in hospital or institution?

3. (a) FULL NAME

Marion Hall

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m.

Colored single.

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

July 21 1947

8. AGE: Years

Months

Days

If less than one day

9 23

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

now.

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03505

157a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Perry Circle

How long in hospital or institution?

3. (a) FULL NAME

Susan Dunnington Harlan

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

July 4, 1946

8. AGE:

1

9

18

Days

If less than one day

hrs.

min.

9. Birthplace

California

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

Richard J. Harlan

MOTHER FATHER

12. Name

Ohio

13. Birthplace

Martha O.T. Bell

14. Maiden name

Maryland

15. Birthplace

Combs R. J. Harlan

16. Informant

Burial

Address

Annapolis, Maryland

17. Burial, cremation, or removal. Which?

Date thereof

4/23/48

(month) (day) (year)

Cemetery or crematory

Natal Cemetery

Location

Annapolis, Md.

18. Funeral director

Address

John M. Taylor

April 23, 1948

(Date rec'd by registrar)

W. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A. A. Co.

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Perry Circle

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 22, 1948, at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 47, to April 22, 1948,

and that I last saw her alive on April 22, 1948.

Immediate cause of death

Hydrocephalus

Due to

Due to

Other conditions

Paralysis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Basil
Annapolis, Md. M. D. or other
Date signed April 22, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. I.M.C. correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03506

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel

County

Crownsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 3 mos.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or Institution? 7 yrs. 3 mos.

3. (a) FULL NAME

NATHANIEL HAYES

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Josephine

6. (c) If alive, give age 68 years

7. Birth date of deceased (mo. day. yr.)

1880

8. AGE:

Years
68

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name Nathaniel Hayes (deceased)

13. Birthplace North Carolina

14. Maiden name

Nancy Martin (deceased)

15. Birthplace

North Carolina

16. Informant

Hospital Records

Address

Crownsville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4-18-48
(month) (day) (year)

Cemetery or crematory

Mt Auburn Et

Location

Balt City

18. Funeral director

Isaiah L. Brown & Son

Address

108 W Montgomery St

19. (Date rec'd by registrar)

19. 4/14

19. 4/8

S. W. Federal

Registrar
JS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 943 Bennett Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

April 13

19. 48 at 10:35a

2D. DATE OF DEATH

October 19. 41 to April 13 19. 48

and that I last saw him alive on April 13 19. 48

Immediate cause of death Chronic Myocarditis known to us since

10/1/47

Due to

Due to

Other conditions Psychosis with Syphilitic since 1/17/41
Meningo-encephalitis (G.P.) known to us 41

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. ---

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of ---

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jacob Hayes

M. D. or other

Crownsville, Md.

4/13/48

Address Date signed

Dr.
Richardson

MARGIN RESERVED FOR BINDING

VS A15
9-45-15MPLEASE WRITE PLAINLY, WITH UNFADING INK.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03507

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Barney Leandras Herndon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored Married

6. (b) Name of husband or wife

Elizabeth Herndon

7. Birth date of deceased (mo. day, yr.)

December 4, 1900

(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

A.A.CO.Md.

(Town, county, and state)

10. Usual occupation

Chauffeur

11. Industry or business

Lovelace Herndon

12. Name

N.C.

13. Birthplace

Malissa Hunt.

14. Maiden name

N.C.

15. Birthplace

Elizabeth Herndon

Simms Crossing, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 6, 1948

(month) (day) (year)

Cemetery or crematory

Brewer Hill

Location

Annapolis, Md.

18. Funeral director

J.B. Johnson

Address

Annapolis, Md. S.C. Box 467

April 6, 1948
(Date rec'd by registrar)D. Daniel
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County Anne Arundel

City or town Simms Crossing, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2, 1948, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1, 1948, to April 2, 1948,
and that I last saw him alive on April 2, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Richardson MD

M. D. or other

Address 110 - 8th St., Annapolis, Md. Date signed 4/6/48

RECEIVED

APR 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03508
1318

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. M. correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County..... Anne Arundel
City or town..... Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

153 Gloucester St.

How long in hospital or institution?

3. (a) FULL NAME

Emma E. Halliday

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

John B. Halliday

6.(c) If alive, give age years

April 30th 1900

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days It less than one day

47 11 2 hrs. min.

9. Birthplace

Halesville, A.O. Co. Md.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

W.W. T. Lyons

A.A. Co. Md.

14. Maiden name Sallie Leatherbury

A.A. Co. Md.

16. Informant

John B. Halliday

Annapolis, Md.

Address

Burial Cedar Bluff Cemetery

(Burial, cremation, or removal. Which?) Date thereof. 7/14/48

Cemetery or crematory

Location Annapolis, Md.

18. Funeral director

John M. Taylor & Son

Address Annapolis, Md.

19. April 4, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A. Co.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1948 at 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19, 48 to April 2 1948

and that I last saw her alive on April 2 1948

Immediate cause of death

Myocarditis + myocardial

Inflammation

Due to

Chemical毒物

Due to

Broadcast

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

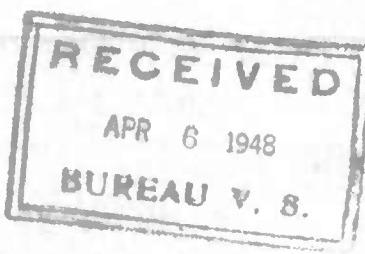
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Smith M. D. or other

Address Annapolis, Md. Date signed 4-3-48





PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. *Like to age*
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

03509
21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, Institution, or street address where death occurred:

5 Pleasant Court

How long in hospital or institution?

3. (a) FULL NAME

Mammie Batson Jackson

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Wesley Jackson

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day. yr.)

June 18, 1900

8. AGE:

Years
47Months
10Days
11

If less than one day

....hrs.min.

9. Birthplace

Annapolis, Maryland

(Town, county, and state)

10. Usual occupation

Laundress

11. Industry or business

None

MOTHER FATHER

12. Name William Thomas Batson

13. Birthplace

Annapolis, Maryland

14. Maiden name

Virgie Jennings

15. Birthplace

Annapolis, Maryland

16. Informant

Elnora Batson Johnson

Address

10 Calvert Court

17. Burial

Date thereof May 2, 1948

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Brewer Hill

Location

West Street Extended

18. Funeral director

Mrs. Charles E. Hicks

Address

43-45 Northwest Street

19. Date rec'd by registrar

April 30, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Pleasant Court

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 28, 1948

at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 23, 1948

to April 28, 1948

and that I last saw her alive on April 28, 1948

Immediate cause of death

Broncho-Pneumonia

DURATION

6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. L. Richardson
Rutherford, Md.

M. D. or other

Date signed 4/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

4-27-48

03510

1

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Anne Arundel
Lake Shore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

M

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

July 12 1897 1898

8. AGE:

Years

Months

Days

If less than one day

#750 7 5 hrs. min.

9. Birthplace

Town, county, and state

Lanc. Md.

10. Usual occupation

Industry or business

Name

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal. Which?

Cemetery or crematory

Location

18. Funeral director

Address

19. Date dece'd by registrar

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If Rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

215-07-8930

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 17 1948 at 1:27 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 11 1948 to April 17 1948

and that I last saw h. s. m. alive on April 16 1948

Immediate cause of death

Coronary Thrombosis

DURATION

1 week

Due to

Due to

Other conditions Hypertensive Cardi - Yes
cular Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Brady Smith M.D.

Address

Burkefield Md. Date signed 4/17/48

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. All correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15 M

DCA 637

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03511

1. PLACE OF DEATH:

County.....

Anne Arundel
Eastport

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry Reckler

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife.....

Elizabeth Reckler

7. Birth date of

deceased (mo., day, yr.)

January 19 1887

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

61

3

10

hrs.

min.

9. Birthplace.....

Phila Pa

(Town, county, and state)

10. Usual occupation.....

Pat 33 year Academy

11. Industry or business

Chgs Reckler

12. Name....

Penn

13. Birthplace

Unknown

14. Maiden name.....

Unknown

15. Birthplace

Unknown

16. Informant.....

Mrs Emily Reckler

Address

Phila Pa

17. Burial.....

Bunil May 3rd 1947

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

St Marys

Location

Annapolis Md

18. Funeral director.....

John M Taylor Sons

Address

Campbell Rd

19. Date rec'd by registrar.....

May 2 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Anne Arundel

City or town.....

Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

50 Eastport Circular Camp

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 29

1948 at 5:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Cardiovascular Disease.

DURATION

Due to.....

Due to.....

Medical Examiner H.H.C.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

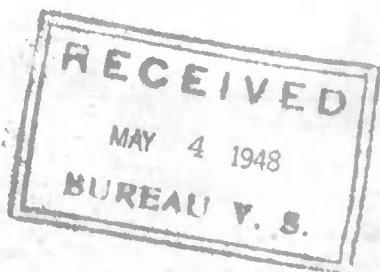
23. SIGNATURE..... M. D. or other

Address..... Date signed.....

Signature..... Date signed.....

Signature..... Date signed.....

Signature..... Date signed.....



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03512

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M
The correct age

1. PLACE OF DEATH:

County

Anne Arundel

City or town

St. Margaret's

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at residence

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Fletcher Kies

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William S. Kies

6. (c) If alive, give age years

August 24th 1870

7. Birth date of deceased (mo., day, yr.)

77 7 18

If less than one day

hrs. min.

8. AGE:

Years

Months

Days

If less than one day

Baltimore, Md.

(Town, county, and state)

9. Birthplace

housewife

10. Usual occupation

Baltimore, Md.

11. Industry or business

housewife

12. Name

Lorraine C. Bush

13. Birthplace

W. Virginia

14. Maiden name

Hannah Skillman

15. Birthplace

New York (state)

16. Informant

Mr. W. S. Kies

Address

St. Margaret's, Md.

17. Burial

Date thereof 4/14/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Margaret's

Location

Q. A. Co. Md.

18. Funeral director

John H. Taylor & Son

Address

Baltimore, Md.

19. Date rec'd by registrar

April 13 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town St. Margaret

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11

1948 at 70 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 1948, to April 11 1948

and that I last saw her alive on April 11 1948

Immediate cause of death

Central nervous system

P. S. I. Paraplegia

DURATION

5 days

Due to

Arteriosclerosis

Due to

Senile

years

Other conditions Ch. arteriosclerosis

Unknown

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

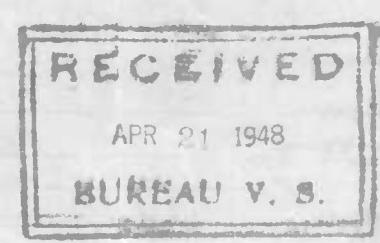
Means of injury Injured at work?

23. SIGNATURE

George L. Bosell M. D. or other

Address Annapolis, Md. Date signed April 13 1948

RECEIVED
APR 14 1948
BUREAU V. S.



~~M~~
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03514
548

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

ANNE ARUNDEL

City or town

MARLEY PARK (Glen Burnie P.O.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

15 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JOHN KRUMHOLZ

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

Hilda Krumholz

Nee YUKKAM

7. Birth date of deceased (mo., day, yr.)

DECEMBER 7, 1893

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

54

4

15

hrs. min.

9. Birthplace

ESTONIA.

(Town, county, and state)

10. Usual occupation

CARPENTER.

11. Industry or business

John Krumholz

Mother Father

12. Name

ESTONIA

13. Birthplace

Maria

14. Maiden name

ESTONIA

15. Birthplace

16. Informant

Mrs. John Krumholz

Address

Marley Park (Glen Burnie, P.O.) Md.

17. Burial

(Burial, cremation, or removal which?)

GLEN HAVEN

Date thereof April 19, 1948
(month) (day) (year)

Cemetery or crematory

GLEN HAVEN

Location

GLEN BURNIE, MD.

18. Funeral director

Thomas W. Duglton

Address

GLEN BURNIE, MD.

19. Date rec'd by registrar

4/20/48

(Date rec'd by registrar)

L. J. M. A. L. H.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

ANNE ARUNDEL

City or town

Marley Park (Glen Burnie, P.O.)

Street No.

Marley Neck Road

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

3. (b) Social Security Number

219-05-1632

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 17, 1948, at 5:30 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15-48 April 17-48 and that I last saw him alive on April 13-48

Immediate cause of death

Bacillus

DURATION

Due to

Malignant

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident suicide, or homicide

Date of

Where did injury occur

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

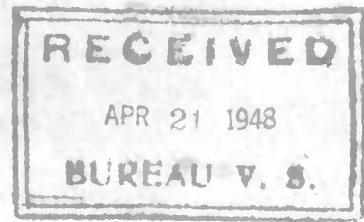
Injured at work?

23. SIGNATURE

Address

Joseph J. Foley
Odenton, MD. Date signed 4-17-48

T



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03515
124 b
1/21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Oxon Hill
 County: Alexandria
 City or town: Alexandria Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: -
 City or town: Bethesda (Mallroad)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2208 Lyndhurst Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Rosedella Lankester

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>F.</u>	<u>W</u>	<u>Widow</u>

6.(b) Name of husband or wife: Kunhard Head.
 7. Birth date of deceased (mo., day, yr.) October 29 - 1873

8. AGE: Years 74 Months 5 Days 24 If less than one day
 hrs. _____ min. _____

9. Birthplace: Hagerstown Md.
 (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business
 MOTHER FATHER
 12. Name: John W. Coats
 13. Birthplace: Frederick Co. Maryland
 14. Maiden name: Sarah Jane Bomberger
 15. Birthplace: Washington Co. Maryland

16. Informant: Mrs. Edward C. Hodder
 Address: 113 Melville Ave, Catonsville Md

17. Burial, cremation, or removal, Which? Buried Date thereof: 4. 26. 1948
 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery
 Location: Hagerstown - Md.

18. Funeral director: A. K. Coopman
 Address: Hagerstown - Md

19. (Date rec'd by registrar) 4/24 1948 L. J. DeAlba
 Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 24 1948 at 10:30 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October - 1947, to April 24 1948
 and that I last saw her alive on 4/22/48.

Immediate cause of death: Internal Hemorrhage DURATION 2 hrs.
 Due to: Esophageal-varices GROSS
 Due to: Portal hypertension 9 "
 Other conditions: Cirrhosis of the liver OUTSIDE

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: _____ Date of: _____

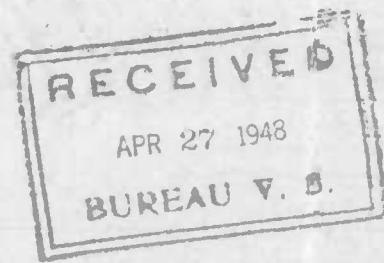
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____ Injured at work? _____

23. SIGNATURE: Rosalee H. Pemberdew M. D. or other _____
 Address: Blair Avenue Md. Date signed: 4/24/48

Decker





Dr. *[Signature]*
M.D.
age
the correct age.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122

03516

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Anne Arundel
City or town... Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 2 weeks

3. (a) FULL NAME

WALTER E. LARRIMORE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife... Nannie B. Larrimore

6.(c) If alive, give age... 52 years

7. Birth date of deceased (mo., day, yr.) October 12, 1894

8. AGE: Years	Months	Days	If less than one day
53	5	26	hrs. min.

9. Birthplace... South River A.A. Co. Md.
(Town, county, and state)

10. Usual occupation... Freight Agent

11. Industry or business... R.R.

12. Name... James E. Larrimore

13. Birthplace... South River

14. Maiden name... Mary W. Purdy

15. Birthplace... South River

16. Informant... Mrs. Nannie E. Larrimore

Address... South River, A.A. Co., Maryland

17. Burial Date thereof... April 11, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory... Cedar Bluff

Location... Annapolis, Maryland

18. Funeral director... Ben L. Hopping and Son

Address... 170-172 West St. Annapolis, Maryland

19. Date rec'd by registrar... April 10, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel
City or town... South River
(If outside city or town limits, write RURAL and give nearest town)

Street No... RFD Annapolis, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 8 1948 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15, 1948, to April 8, 1948, and that I last saw her alive on April 8, 1948.

Immediate cause of death... Coronary thrombosis
Duration... Since

Due to... Coronary Dystrophy Duration... 3 weeks

Due to... Obstruction of arteries Duration... 3 days

Other conditions... (Include pregnancy within 3 months of death)

Major findings or operations... Volvulus of cecum
Date of op... 4-4-48

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

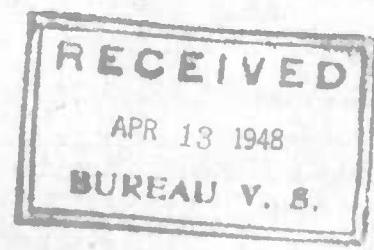
Means of injury... Injured at work?

23. SIGNATURE... George E. Boal

M. D. or other

Date signed... April 9, 1948

Address... Annapolis, Maryland



Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

94a
pe
03517
Reg. Dist. No.

HM No. G 115 APR 16 1948 CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Anne Arundel
Baltimore - P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 hrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Milton Lee

4. Sex

M. Colored. married

6. (b) Name of husband or wife

Martha Martin

7. Birth date of deceased (mo., day, yr.)

June 2 1874

6. (c) If alive, give age 7 years

8. AGE:

Years Months Days If less than one day

73 7 10 6

hrs. min.

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Minister

11. Industry or business

Robert E. Lee

12. Name

Virginia

13. Birthplace

Louisville, Ky.

14. Maiden name

Louise Webster

15. Birthplace

Virginia

16. Informant

George E. Lee

Address

Pasadena - Md.

17. Burial

Date thereof Apr 11-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

April 11 1948

Cemetery or crematory

Md - Auburn

Location

Jasmine Apartments

142 W. 3rd St

Address

142 W. 3rd St

18. Funeral director

James A. Hayes

Address

142 W. 3rd St

19. Date rec'd by registrar

April 9 1948

(Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1133 N. Baltimore St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

19. 19.

Immediate cause of death

Ischaemic Occlusion suddenly

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Franklin W. Packard, M.D.

Deputy Medical Director

Address

Islemon Building

Date signed

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03518

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 345

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs.

Hospital, Institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 3 hrs.

3. (a) FULL NAME

Charles Lipscomb

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MWSingle

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

May 12, 1929

8. AGE:

Years

Months

Days

If less than one day

18hrs.min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Mechanics helper

11. Industry or business

12. Name Theodric B. Lipscomb13. Birthplace Tupelo, Maryland14. Maiden name Anna Panushka15. Birthplace New York State16. Informant Theodric B. LipscombAddress 2714-26th St. N.E. Wash. D.C.17. Burial Date thereof April 28-1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln CemeteryLocation Colmar Manor, Prince George's Co., Md.18. Funeral director William J. ValleyAddress 3200 - R.J. Ave. Mt. Rainier, Md.19. Date rec'd by registrar April 29, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2714

26th St. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Apr. 25 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10

to

19

and that I last saw him alive on

19

Immediate cause of death

Cerebral hemorrhage

Due to

Fracture of skull

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

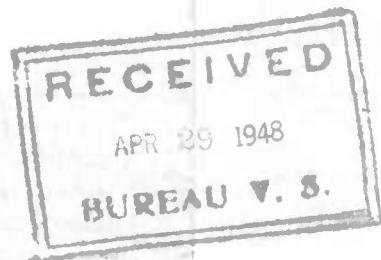
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Apr. 25, 1948Where did injury occur? Route 214 (City or town) A.A. (County) Md. (State)Injured at home, farm, industry, public place (where?) HighburyMeans of injury Auto collision Injured at work?23. SIGNATURE E. Peyton Pitcher, M.D.Address Annapolis, Md. Date signed Apr. 25, 1948



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is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9/10

03519

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anna Arundel

City or town Rosedale Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, Institution, or street address where death occurred:

Brown Street Rd.

How long in hospital or institution?

3. (a) FULL NAME

George Albert Lucker

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced M

8. (b) Name of husband or wife Mrs. James Wm. Lucker

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1889

8. (c) If alive, give age 57 years

8. AGE:

Years 59

Months 1

Days 24

If less than one day hrs. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation laborer

11. Industry or business Plumbing supplies

MOTHER FATHER

12. Name Edward J. Lucker

13. Birthplace Md.

14. Maiden name Eugenia Barnett

15. Birthplace Md.

16. Informant Geo. Albert Lucker - Info

Address Rosedale Bay - Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4/5/48

(month) (day) (year)

Cemetery or crematory London

Location Balt.

18. Funeral director Wm. J. Tucker & Sons

Address Balt.

19. (Date rec'd by registrar) 19

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anna Arundel

City or town Rosedale Bay - Anna Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 1 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10. 19.

and that I last saw him alive on

Immediate cause of death

coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Peyton Ritelman, M.D.
Annapolis, Md.

Date signed Apr. 2, 1948

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03520
128

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

Anne Arundel County

Crownsville City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 17 days

3. (a) FULL NAME

LILLY LUMPKINS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female negro married

6.(b) Name of husband or wife William Lumpkins

7. Birth date of deceased (mo. day yr.) 1904 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
44 hrs. min.

9. Birthplace Newberry, South Carolina

(Town, county, and state)

Housewife

10. Usual occupation

11. Industry or business

12. Name Nathan Cook, South Carolina

13. Birthplace South Carolina - Newberry

14. Maiden name Ella Marshall (deceased)

15. Birthplace Newberry, South Carolina

16. Informant Hospital Records

Address Crownsville, Md.

17. Burial

(Burial, cremation, or removal, Which?) Date thereof 4/26/48

Cemetery or crematory Arbutus Cemetery

Location Arbutus Memorial Park, Md.

18. Funeral director Mrs. Katie R. Williams

Address 322 N. Schroeder St. Baltimore

19. (Date rec'd by registrar) 4/26/48

19.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland State

County

Baltimore City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 N. Poppleton St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22

19. 48 at 11:35p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19. 48 to April 22 19. 48

and that I last saw her alive on April 22 19. 48

Immediate cause of death Exhaustion Delirium

known to us since

DURATION

4/18/48

Due to Acute Hemorrhagic Pancreatitis known to us since

4/18/48

Due to

Other conditions Schizophrenia known to us since

4/5/48

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Acute Hemorrhagic Pancreatitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Crownsville, Md.

Date signed 4/22/48

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03521

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred.....

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

4 - 20 - 48 19 6:30 P.M.

21. I IDENTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1948 April 20, 1948 and that I last saw him alive on April 17, 1948.

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Due to.....

Other condition.....

Cardiovascular Disease
(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Date signed.....

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a
03522
21

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel

City or town Glen Burnie, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alexander A. Markoff

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Divorced

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 13, 1874

8. AGE:

Years

Months

Days

If less than one day

73

10

8

hrs.

min.

9. Birthplace Kertch, Russia

(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business Hutzler Brothers

Alexander Markoff

MOTHER

FATHER

12. Name

Russia

13. Birthplace

Unknown

14. Maiden name

Russia

15. Birthplace

Mrs Beulah Murray

16. Informant

Address 3836 Eighth St. Brooklyn 25, Md.

17. Burial

Date thereof April 24, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Glen Haven

Location

Glen Burnie, Md.

18. Funeral director

Thomas W. Singleton

Address

Glen Burnie, Md.

19. (Date rec'd by registrar)

19. 4/21/48

Z. J. De Alba

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Anne Arundel

City or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Fifth Ave. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

214-01-1161

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 1948 a.m. 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to April 21, 1948

and that I last saw him alive on April 21, 1948

19

Immediate cause of death

Coronary Thrombosis 1 hr.

DURATION

Due to Generalized sclerosis 7 yrs

Due to

Other conditions Prostatitis - 21/48

DURATION

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

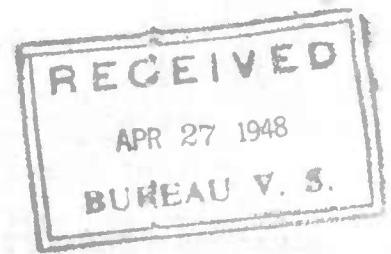
Means of Injury

Injured at work?

23. SIGNATURE Gustave A. Paucker M.D.

M. D. or other

Address Glen Burnie, Md. Date signed 4/21/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462
03523

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Benfield (Millersville Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 16 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

RUTH GABRIEL MARSHECK

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife..... Frank M. Marsheck

7. Birth date of deceased (mo. day, yr.)..... January 12, 1901

8. AGE: Years Months Days It less than one day
47 3 6 hrs. min.9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Own Home

FATHER 12. Name..... James H. B. Woodrow

13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Mary E. Forrest

15. Birthplace..... Maryland

16. Informant..... Mrs. Sadie I. Lloyd

Address..... 803 Wise Ave., Baltimore 22, Md.

17. Burial Date thereof..... April 21, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Glen Haven

Location..... Glen Burnie, Md.

18. Funeral director..... Thomas W. Singleton

Address..... Glen Burnie, Md.

19. 4/21 1948 Z. J. Walker
(Date rec'd by registrar) (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Anne Arundel
 City or town..... Benfield (Millersville Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. Box 44 Crain Highway
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 18 48 at 10.50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan - 15 - 1948 to April 18 1948
and that I last saw her alive on April 18 1948

Immediate cause of death.....

Diseases of heart

DURATION

2 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

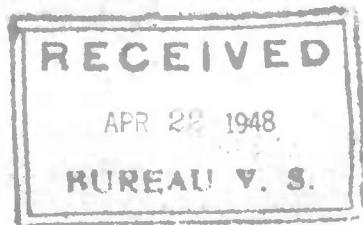
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... chas. L. Baez, M.D. or other
Address..... Linthicum Heights, Md. Date signed..... 4/19/48



I PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. In case of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03525
21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel County
City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 6 mos. 6 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 5 yrs. 6 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

City or town Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 N. Carey St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Rosa McLamb

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female negro Married

6.(b) Name of husband or wife George McLamb

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
44 --- --- . hrs. . min.9. Birthplace North Carolina
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

MOTHER FATHER 12. Name Gavel Windfield

13. Birthplace

14. Maiden name Lucinda ?

15. Birthplace

16. Informant Hospital records

Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 14-20-48
(month) (day) (year)

Cemetery or crematory Mount Auburn

Location Balt. Md

18. Funeral director John Katie P. Williams

Address 3223 S. Charodier St

19. 4-20-48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948 at 7:30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/42, 1942, to 4/16/48, 1948, and that I last saw her alive on April 16, 1948.

Immediate cause of death Pulmonary embolism known to us since 3/27/48 DURATION

Due to.

Due to.

Other conditions Schizophrenia Known to us since 20/23/48

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob M. Mycute, M.D. M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03524
28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 18 days

3. (a) FULL NAME

NAOMI MEDLEY

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	widowed

6.(b) Name of husband or wife _____ deceased

7. Birth date of deceased (mo. day. yr.) 1878

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name _____

13. Birthplace _____

14. Maiden name _____

15. Birthplace _____

16. Informant Hospital records

Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?)

Date thereof 4-13-48
(month) (day) (year)

Cemetery or crematory Ingolds Md

Location Md

18. Funeral director George S. Nelson

Address 1303 Presstown St

19. (Date rec'd by registrar) 4/12/48 A.W. Hedrick
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ---

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2519 Salem Street

(If rural, give LOCATION) ---

2.(a) If veteran, name war. ---

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948 at 3:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1948 to April 9 1948

and that I last saw her alive on April 9 1948

Immediate cause of death Cerebral Hemorrhage known to us since

Due to. 3/22/48

Due to. 3/22/48

Other conditions Senile psychosis known to us since

(Include pregnancy within 3 months of death) 3/22/48

Major findings of operations Date of op. ---

Autopsy results. Date of op. ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury Injured at work? ---

23. SIGNATURE Jacob Maycutter M.D.

M. D. or other

Address Crownsville, Md. Date signed 4/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

562

03526

21

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 6 days

3. (a) FULL NAME

Mary J. Muller

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Henry A. Muller6. (c) If alive, give age 32 years

7. Birth date of deceased (mo. day, yr.)

Feb. 14, 1916

8. AGE:

Years
32Months
1Days
20If less than one day
hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Clark

11. Industry or business

Petrol Oil Co. Annapolis

MOTHER FATHER

12. Name

Adolphus Neuman

13. Birthplace

Hermanns

14. Maiden name

Mary Maxwell

15. Birthplace

Baltimore, Md.

16. Informant

Henry Muller

Address

Rivd. Md.

17. Burial

April 7-1948

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Glen Haven Cemetery

Location

Pitchell Highway

18. Funeral director

Frank Funeral Home

Address

1216 N. Charles St.

Date rec'd by registrar

April 5, 1948

(Date rec'd by registrar)

19.19.20.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Anne ArundelCity or town River

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

212-07-5864

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 4, 1948, at 12¹⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28, 1948, to April 3, 1948.and that I last saw her alive on April 3, 1948.

Immediate cause of death

Cardiorespiratory failure

Due to

Paralytic illness

Due to

Peritonitis

Other conditions

Endometriosis

(Include pregnancy within 8 months of death)

Major findings or operations

Endometriosis involving sigmoid colonDate of op. Mar. 29, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchings, M.D.

M.D. or other

Address Annapolis, Md.Date signed April 4, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

03527

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County Pet Road, H. County
City or town P.S. Pasadena
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Few seconds.

Hospital, institution, or street address where death occurred:

Mountain Road,

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male alive married

6. (b) Name of husband or wife

Margaret C.

7. Birth date of deceased (mo., day, yr.)

May 12 - 1896

8. AGE: Years Months Days If less than one day

51 11 4

hrs. min.

9. Birthplace Baltimore - Md.

(Town, county, and state)

10. Usual occupation Contractor & Builder11. Industry or business " "12. Name David F. Neighoff13. Birthplace Maryland14. Maiden name Katherine Aegeer15. Birthplace Maryland16. Informant Margaret C. NeighoffAddress 219 Hornewood Road17. Suicide Date thereof April 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory New HavenLocation New Haven - Md.18. Funeral director J. B. Alspach & SonAddress 100 Fulton Place19. 4/19/48 Date rec'd by registrar19. 4/19/48 Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A. CountyCity or town Linthicum (If outside city or town limits, write RURAL and give nearest town)Street No. 219 Hornewood Road (If rural, give LOCATION)2.(a) If veteran, name war W.W. I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 19 48 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on 19...

Immediate cause of death Frosting of shell" of fracture -" of fracture -fracture of skull -fracture of mandible -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -fracture of ulna -fracture of tibia -fracture of fibula -fracture of sacrum -fracture of coccyx -fracture of vertebrae -fracture of ribs -fracture of sternum -fracture of clavicle -fracture of scapula -fracture of humerus -fracture of radius -

<u

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03528

46d

Reg. Dist. No.

21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... A.A.

City or town..... Ferndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

109 Baltimore Avenue

How long in hospital or institution?

3. (a) FULL NAME

George Edward Palmer

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband ~~now~~ Louise A. Palmer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12th 1884

8. AGE: Years	Months	Days	If less than one day
64	1	3	hrs. min.

9. Birthplace..... Penna
(Town, county, and state)

10. Usual occupation..... Brick Layer

11. Industry or business

12. Name..... August Palmer

13. Birthplace..... Penna

14. Maiden name..... Eliza Diehl

15. Birthplace..... Penna

16. Informant..... Mrs. Louis A. Palmer

Address 109 Baltimore Ave. Ferndale 25 Md.

17. Burial..... Date thereof April 19th 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Lorraine

Location..... Baltimore County, Md.

18. Funeral director..... Wm. J. Tickner & Sons

Address..... North & Penna Aves.

19. Date rec'd by registrar..... 4/16/48

1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... A.A.

City or town..... Ferndale

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 109 Baltimore Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

?

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 15th 1948

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15 1947 to April 10 1948
and that I last saw him alive on April 10 1948

Immediate cause of death..... Chronic Myocarditis

DURATION 1 yr.

Due to.....

Due to.....

Other conditions..... Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... George Edward Palmer

M. D. or other.....

Address.....

Date signed..... 4-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03529

21

193
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

A.A. Co.

City or town.....

Magothy Manor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William D. Polk

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Thelma M. Polk

7. Birth date of deceased (mo., day, yr.)

Mar 9th 1921

(c) If alive, give age

years

8. AGE:

Years
27Months
1Days
6

If less than one day

hrs.

min.

9. Birthplace.....

Balto. Md.

(Town, county, and state)

10. Usual occupation.....

Lineman

11. Industry or business

C & P Telephone Co

MOTHER FATHER

12. Name.....

Frederick Polk

13. Birthplace.....

Balto. Md.

14. Maiden name.....

Mary

e.

"

"

15. Birthplace.....

Balto. Md.

16. Informant.....

Thelma Polk

Address

#1 Kiel Rd., Magothy Manor

17. Burial

Date thereof

4/19/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

U.S. National

Location.....

Balto. Md.

18. Funeral director.....

William Polk Inc

Address

1217 St. Paul St. Balto. 2 Md.

19. Date rec'd by registrar

April 17 1948

A.W. Hefner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

A.A. Co.

City or town.....

Magothy Manor

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

#1 Kiel Rd (Arnold P.O.)

(If rural, give LOCATION)
W.W. #2

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-12-7498

MEDICAL CERTIFICATION

2d. DATE OF DEATH

April 15th 1948 at

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19.....

to.....

19.....

and that I last saw h..... alive on

Immediate cause of death.....

Electrocution

DURATION.....

Sudden

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

4/15/48

Where did injury occur?.....

City or town)

Baltimore

(County)

Md

(State)

Injured at home, farm, industry, public place (where)?.....

Road

Means of injury.....

Injured at work?

Yes

23. SIGNATURE

Gustav D. Pauley, M.D.

Assistant to medical examiner

New Business Rd.

Date signed 4/15/48

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03530

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANN ARUNDEL

City or town ANNAPOLIS, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S.N. HOSPITAL, ANNAPOLIS, MARYLAND

How long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ANN ARUNDEL

City or town RURAL, ANNAPOLIS, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

Street No. WELMS CREEK

(If rural, give location)

2.(a) If veteran, name war WORLD WAR I & 2

3. (b) Social Security Number

3. (a) FULL NAME

POWERS, Angus James

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6. (b) Name of husband or wife FANNY A. POWERS

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) OCTOBER 2, 1896

8. AGE: Years Months Days If less than one day

51 6 11 hrs. min.

9. Birthplace Gloucester, Massachusetts
(Town, county, and state)

10. Usual occupation U.S. NAVY RETIRED

11. Industry or business

Deceased
12. Name unknown

13. Birthplace

Deceased
14. Maiden name unknown

15. Birthplace

16. Informant Daughter: Mrs. Kathryn Small

Address 1402 Isted Road, Harundale, Glenn Burnie

17. Burial Date thereof April 15, 1948
(Burial, cremation, or removal, Which?) Maryland

(month) (day) (year)

Cemetery or crematory arlington

Location arlington Va

18. Funeral director 13 L. T. & Sons

Address annapolis, md

April 15, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1948 at 150 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13 April 1948 to 13 April 1948

and that I last saw him alive on 13 April 1948

Immediate cause of death

PULMONARY EDEMA

DURATION

Due to MYOCARDIAL INFARCTION

Due to ARTERIOSCLEROTIC HEART
DISEASE

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R.H. SHEPARD M.D. or other
Lt. (jg) (MC)

Address U.S.N.H. ANNAPOLIS, MD. Date signed 4-13-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03531

50

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County... Anne Arundel
City or town... Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Una Mae Purdie

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Joseph M Purdie

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 29 1883

8. AGE:

Years 64 Months 7 Days 1 It less than one day hrs. min.

9. Birthplace

Ashboro N.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Joseph C. Bulla

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly, is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel

City or town... Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No... 2 Murray Ave (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 3 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 10 to April 3 1948

and that I last saw her alive on April 3 1948

Immediate cause of death

Recurrent Cerebral

Burst, Cerebral Brain

4 years

Due to

Cerebral Burst

1940 DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Cerebral Burst

Date of op. Aug 1940

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

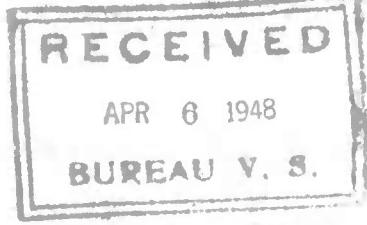
Means of injury Injured at work?

23. SIGNATURE

George C. Bassil M.D. or other

Annapolis Md. Date signed April 3 1948

Registrar





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

03532

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age.....years

8. AGE:

Years Months Days If less than one day
54 3 24 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

Burial Date thereof.....
(Burial, cremation, or removal. Which?) May 1, 1948
(month day year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. April 29, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

21. monuments st

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 27 1948 21 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 17, 1948 to April 23, 1948

and that I last saw her alive on April 14, 1948

Immediate cause of death.....

acute dilatation
of heart

Due to.....

hernia & pneumonia

DURATION

6 weeks

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

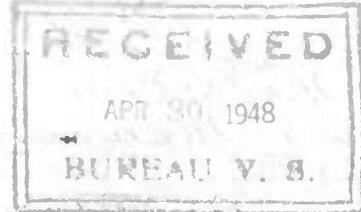
Injured at work?

23. SIGNATURE.....

Edith Roellig, Jr.
M. D. or other

Address..... 42 State Circle Annapolis, Md. Date signed..... Apr. 28, 1948

Registrar





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03533

97

CERTIFICATE OF DEATH

28

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 12 days.
 Hospital, institution, or street address where death occurred: Crownsville State Hospital
 How long in hospital or institution?..... 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 554 Wilson St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... World War I

3. (a) FULL NAME

JAMES RICE

3. (b) Social Security Number

4. Sex MALE	5. Color or race NEGRO	6.(a) Single, married, widowed, or divorced SINGLE
----------------	---------------------------	---

6.(b) Name of husband or wife..... None

7. Birth date of deceased (mo. day, yr.) Sept. 1, 1893
 (Year must be given)

8. AGE: Years 55 Months Days It less than one day
 hrs. min.

9. Birthplace..... Virginia
 (Town, county, and state)

10. Usual occupation..... Unemployed - cook in U.S. Army

11. Industry or business.....

MOTHER FATHER	12. Name..... Unknown
---------------	-----------------------

MOTHER FATHER	13. Birthplace.....
---------------	---------------------

MOTHER FATHER	14. Maiden name..... Unknown
---------------	------------------------------

MOTHER FATHER	15. Birthplace.....
---------------	---------------------

16. Informant..... Hospital Records

Address..... Crownsville, Md.

17. Burial, cremation, or removal? Which?..... buri Date thereof 4/7/48
 (month) (day) (year)

Cemetery or crematory..... BALTIMORE
 Location..... NATIONAL CEM.

18. Funeral director..... J. Brooks Beiggold

Address..... 1463 N. Carey St.

19. (Date rec'd by registrar) 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1948 at 7:42 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1948 to April 3 1948 and that I last saw him alive on April 3 1948

Immediate cause of death..... gen. arteriosclerosis
 Known to me since 3-21-48

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

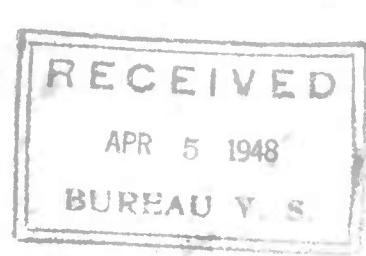
Means of injury..... Injured at work?

23. SIGNATURE..... Jacob Margolin, M.D.

M. D. or other

Date signed 4/5/48

Address..... Crownsville, Md.



RECEIVED
APR 29 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03535
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town EASTPORT

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

AT RESIDENCE

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth SEGELKEN

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

FREDERICK SEGELKEN

7. Birth date of deceased (mo., day, yr.)

OCTOBER 28th 1868

6. (c) If alive, give age years

8. AGE:

Years 79Months 5Days 29

If less than one day

hrs.

min.

9. Birthplace

NEW YORK, N.Y.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

UNKNOWN

12. Name

UNKNOWN

13. Birthplace

UNKNOWN

14. Maiden name

UNKNOWN

15. Birthplace

UNKNOWN

16. Informant

MR. FREDERICK SEGELKEN

Address

EASTPORT, MD.

17. Burial

Date thereof 4/30/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

CEDAR BLUFF CEMETERY

Location

ANNAPOLIS, MD.

18. Funeral director

JOHN M. TAYLOR - SON

Address

ANNAPOLIS, MD.

19. April 28 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1935 to April 26 1948and that I last saw her alive on April 26 1948

Immediate cause of death:

Myocarditis Ch. 5Myocardial degenerationArteriosclerosis

DURATION

10 years

Due to:

ArteriosclerosisMyocardial degenerationArteriosclerosisUnknown

Other conditions

Marked Senility2 yearsSenility

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

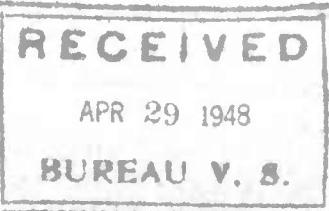
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George B. Basile

M. D. or other

Address Annapolis, MD.Date signed 4/26/48



I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03536

21

Reg. Dist. No.....

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town ANNAPOLIS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

37 Madison St.

How long in hospital or institution?

3. (a) FULL NAME

CHRISTIAN A SEIM Sr.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALEWHITEMarried

6.(b) Name of husband or wife

Agnes May Seim

7. Birth date of deceased (mo., day, yr.)

Jan 17th 1876

(c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Baltimore, Md.

10. Usual occupation

Retired

11. Industry or business

Gas & Electric Co.

MOTHER FATHER

12. Name

Henry V. Seim

13. Birthplace

Germany

14. Maiden name

Margaret Disterway

15. Birthplace

Germany

16. Informant

Agnes May Seim

Address

37 Madison St. - Annapolis, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/12/48 (month) (day) (year)Baltimore

Cemetery or crematory

Location

" Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

19.

4/8A. W. Hydrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLANDCounty ANNE ARUNDELCity or town ANNAPOLIS

(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 MADISON ST.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

212-05-7287

MEDICAL CERTIFICATION

20. DATE OF DEAT

April 8

19.

48

al

9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1948 to April 8 1948and that I last saw him alive on April 8 1948

Immediate cause of death

Cerebral HemorrhagePt. Hemiplegia

Due to

Arterial Thrombosis

Due to

Myocarditis Ch.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Agnes M. Basil

M. D. or other

Address Annapolis, Md. Date signed 4-8-48

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03537
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:
 205 Chester Ave. Eastport, Md.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 205 Chester Ave.
 (If rural, give LOCATION)

3. (a) FULL NAME
 Mary Magdalena Maggie Ann Shaw

3. (b) Social Security Number
 None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married

6. (b) Name of husband or wife..... Alexander Shaw

7. Birth date of deceased (mo., day, yr.) July 30, 1879
 6. (c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
69	8	24	hrs. min.

9. Birthplace..... Churchton Md. Anne Arundel Co.
 (Town, county, and state)

10. Usual occupation..... Housewife
 None

11. Industry or business.....
 12. Name..... James Anderson

MOTHER FATHER
 13. Birthplace..... West River Anne Arundel Co.

14. Maiden name..... Unknown

15. Birthplace..... West River Anne Arundel Co.

16. Informant..... Alexander Shaw

Address..... 205 Chester Ave

17. Burial..... Date thereof..... April 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Brewer Hill Cemetery
 Location..... West Street Extended

18. Funeral director..... Mrs. Charles E. Hicks

Address..... 43-45 Northwest Street

19. Date rec'd by registrar..... April 28, 1948
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 23, 1948, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22, 1948, to April 23, 1948,

and that I last saw him alive on _____

Immediate cause of death..... Cardiac Failure

Due to..... Hypertensive Cardiac Vasculitis
 Disease

Duration..... 2 days

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op._____

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

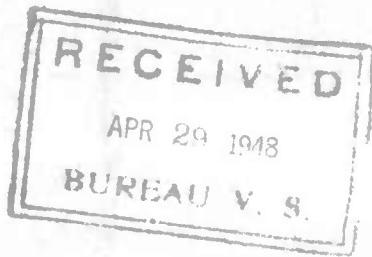
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Harley J. Shankel
 M. D. or other

Date signed..... April 28, 1948

Address..... 40 North West Street





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Time correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

03538

21

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Anne Arundel

City or town

Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at residence

How long in hospital or institution?

3. (a) FULL NAME

Effie Smith

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Charles Smith

7. Birth date of deceased (mo., day, yr.)

December 30, 1869

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

78

3

3

hrs.

min.

9. Birthplace

Annapolis, G.O. Co., Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

Alexander Evans

MOTHER FATHER

12. Name

Alexander Evans

13. Birthplace

Maryland

14. Maiden name

Evans

15. Birthplace

Maryland

16. Informant

Mr. Matthew Evans

Address

Seneca Pk., Md.

17. Burial

Date thereof. 4/5/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis, Md.

April 5, 1948

(Date rec'd by registrar)

- O. Frank

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Md.

County

A. Q. Co.

City or town. Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 617

Chesapeake Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2, 1948, at 3:11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1948, to April 2, 1948, and that I last saw her alive on April 2, 1948.

Immediate cause of death

Coronary Thrombosis

Duration

Due to

Due to

Other conditions

Arteriosclerotic Cardio-Vascular Disease

5 yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

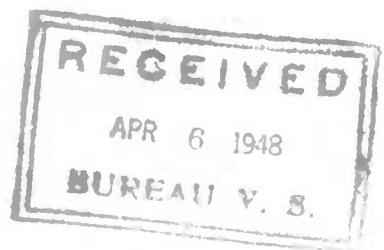
M. D. or other

Address

Albert H. Anderson, Jr.

Annapolis, Md.

Date signed April 7, 1948.



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03540

2d

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

An A. Co.

City or town.....

Jewell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Mary Stark

4. Sex

F

5. Color or race

COL

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

1859

6. (c) If alive, give age..... years

8. AGE:

Years
89Months
1Days
1If less than one day
hrs. min.

9. Birthplace.....

A. A. Co.

(Town, county, and state)

10. Usual occupation.....

Home work

11. Industry or business.....

MOTHER FATHER

12. Name.....

Wm. Stark

13. Birthplace.....

A. A. Co.

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Address

Gladys Reed

Jewell, Md.

17. Burial (Burial, cremation, or removal. Which?)

Burial

Date thereof

Apr 9 1948

(month)

(day)

(year)

Cemetery or crematory.....

Location

Greenfield Cem.

Friendship

18. Funeral director.....

Address

O. S. Standard & Son

Halesville, Md.

19. (Date reg'd by registrar)

4/9

1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

A. A. Co.

City or town.....

Jewell

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 6

19.

48

at

7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 29 1948 to April 6 1948

and that I last saw her alive on April 5 1948

Immediate cause of death.....

cerebral hemorrhage

DURATION

Due to.....

hypertension

Due to.....

arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

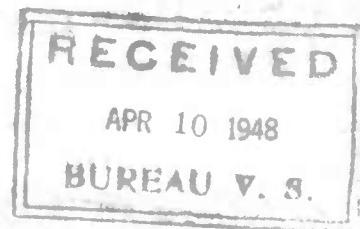
Emil H. Hibem M.D.

M. D. or other

Address.....

Loftman

Date signed 4-8-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03541
83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 2 hours

Hospital, Institution, or street address where death occurred:

Emergency HospitalHow long in hospital or institution? 12 hrs

3. (a) FULL NAME

Carrie Anna Starlings

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William P. Starlings

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 24, 1889

8. AGE:

58

Years

Months

Days

If less than one day

21

hrs.

min.

9. Birthplace

Bidwell's, A.A., Md.

(Town, county, and state)

10. Usual occupation

Name wife

11. Industry or business

John Done

12. Name

John Done

13. Birthplace

A.A. Co. Md.

14. Maiden name

Annie Robertson

15. Birthplace

A.A. Co. Md.

16. Informant

Wm P. Starlings

Address

Anne Arundel

Burial

Burial Date thereof Apr. 18 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

All Hallows Cemetery

Location

A.A. Co. Md.

18. Funeral director

John M. Taylor Son

Address

Annapolis Md

April 18, 1948

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Rural - Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 15 1948at 10:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 10 1948 to Apr. 15 1948and that I last saw her alive on Apr. 14 1948

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

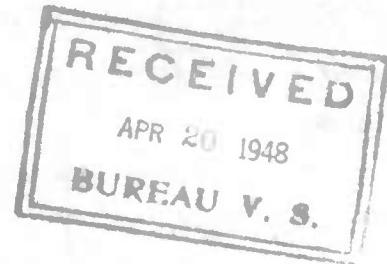
Means of injury

Injured at work?

23. SIGNATURE E. Peyton Ritelman, M.D.

M. D. or other

Address Annapolis, Md. Date signed Apr. 18, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03542

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs. 1 mo.
 Hospital, institution, or street address where death occurred: Crownsville State Hospital
 How long in hospital or institution? 6 yrs. 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1117 Park Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

CORNELIA TARTAR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) 1888 (approximately 60 yrs)

8. AGE: Years 60? Months Days It less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

MOTHER FATHER 12. Name Samuel Cook

13. Birthplace Maryland

14. Maiden name Harriett Williams

15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville, Md.

17. Burial Date thereof 4/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18. Funeral director Miss Frances Hembler

Address 578 W. Biddle St., Baltg.

Date rec'd by registrar Apr 22 1948 E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948 at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1942, to April 21, 1948,

and that I last saw her alive on April 21, 1948.

Immediate cause of death General Paresis known to us since 3/12/42

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

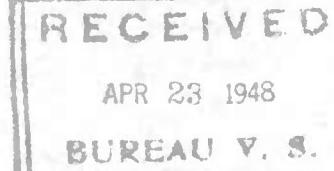
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE M. D. or other

Address Crownsville, Md. Date signed 4/21/48



Evidence for change of Item 6a
is shown on Film G116 6/21/48 js
Marriage Record Dated 9/15/41

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1702
03543

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Annie Arundel
County: Maryland
City or town: Marygate - P.O. Baltimore 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five seconds.
Hospital, Institution, or street address where death occurred:
Furnace Branch Road.
How long in hospital or institution?

3. (a) FULL NAME
Charles Thomas

4. Sex: M. 5. Color or race: Colored. 6. (a) Single, married, widowed, or divorced: Married
Cassie M. Smith

6. (b) Name of husband or wife: Cassie M. Smith

7. Birth date of deceased (mo., day, yr.): July 5-1920 6. (c) If alive, give age: years

8. AGE: 27 Years Moors Days It less than one day
hrs. min.

9. Birthplace: Woodville Fla. (Town, county, and state) Seminole

10. Usual occupation: Sale

11. Industry or business
MOTHER / FATHER: 12. Name: Jessie Thomas (dr.)
13. Birthplace: Woodville Fla.
14. Maiden name: Daisy Dawson
15. Birthplace: Ta

16. Informant: Jessie Thomas Jr.
Address: 430 E. Sansvale St

17. Burial: Burial Date thereof: April 29-1948
(Burial, cremation, or removal, Which?) (Month) (day) (year)
Cemetery or crematory: Baptist Cemetery
Location: Georgia

18. Funeral director: Robert & Williams
Address: 1515 McTiderry St

19. (Date rec'd by registrar) April 27-48 A. A. Hedrick
Address: 1515 McTiderry St Registrars

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore 5
City or town: Baltimore 5
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 637 - N. Caroline St.
(If rural, give LOCATION)

2.(a) Is veteran, name war?

3. (b) Social Security Number
253-16-1557

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 1948 at 7:45 A.M.
19. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. ... to 19. ...
and that I last saw h. ... alive on 19. ...

Immediate cause of death: Fracture (compound) of skull DURATION Sudden
Due to: Fracture of both humerus
SADDLE.

Due to: ...

Other conditions: ...

(Include pregnancy within 3 months of death)

Major findings of operations: ...

Date of op.

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Buried Date of: 4/29/48
Where did injury occur? Marygate (City or town) A.A. 2nd (County) (State)
Injured at home, farm, industry, public place (where)? Furnace Branch Rd.
Means of injury: Buried Injured at work? No

23. SIGNATURE: Secretary of State
Any Deputy medical examiner M. or other
Address: 1515 McTiderry St Date signed 4/29/48

Officer John Broley
A.A. Co Blue Sept
Fondale W.L.

STATE OF MARYLAND—CERTIFICATE OF DEATH

03544

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Anne Arundel.

Registration Dist. No. 21

Village or City Round Bay, Seaville Pt. P.O.

No. Askuton Road

St.

Ward

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U.S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Sudie Francis Thompson.

If U. S. Veteran, specify WAR

(a) Residence: No. Round Bay, Seaville Pt. P.O. St. Not Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed.
---------------	------------------------	--

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred P. Thompson.

6. DATE OF BIRTH (month, day, and year)	March 27, 1870		
7. AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
78	0	18	

OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	at home	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	Housewife.	
10. Date deceased last worked at this occupation (month and year)	2 yrs	11. Total time (years) spent in this occupation	all

12. BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

13. NAME Jacob Louis.

14. BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

15. MAIDEN NAME Susan Porter

16. BIRTHPLACE (city or town)
(State or country) Baltimore, Md.17. INFORMANT Mrs. Raymond Thompson
(Address) 5201 Belvoir Rd., Seaville Pt. P.O.18. BURIAL, CREMATION, OR REMOVAL
Place Cemetery Date 4-17-194819. UNDERTAKER Stewart Monroe
(Address) 108 W North Ave.20. FILED 4/16/1948 A. W. Hedrick
DM Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 13, 1948

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1940, to April 13, 1948

I last saw her alive on April 13, 1948; death is said

to have occurred on the date stated above, at 11 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral Hemorrhage

Date of onset
24 hours

Other Contributory Causes of importance:

Cardio-Vascular Disease

5 years

Name of operation _____ Date of _____

What test confirmed diagnosis? Symptom Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? Yes

If so, specify _____

(Signed) John J. Bellinger, M.D.
(Address) 200 Baltimore, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN



PLEASE WRITE PLAINLY, IN PUFF UNFADING INK. Supply every item of information carefully, but correct if especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03545
28

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

Anne Arundel
County
Crownsville

(If outside city or town limits, write RURAL and give nearest town)

20 yrs. 2 mos.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution?

20 yrs. 2 mos.

3. (a) FULL NAME

VIOLET TURNER

4. Sex female	5. Color or race negro	6.(a) Single, married, widowed, or divorced single
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6.(b) Name of husband or wife: —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1907

8. AGE: Years 40 Months 8 Days 8 If less than one day hrs. min.

9. Birthplace St. Mary's County, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Henry Turner

13. Birthplace Maryland

14. Maiden name Elisa Turner

15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville, Md.

17. Burial Date thereof 4/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns

Location Hollywood, Md.

18. Funeral director W. C. Mattingley Sons.

Address Leonardtown, Md.

19. 4/15-48 (Date rec'd by registrar)

E. F. Joyce Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County St. Mary's

Hollywood

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 1948 at 11:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941 to April 15 1948 and that I last saw her alive on April 15 1948

Immediate cause of death

Cerebral Hemorrhage

Due to

Due to

Other conditions Dementia Praecox

known to us since

(Include pregnancy within 3 months of death)

2/21/28

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Crownsville, Md.

Date signed

4/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

03546

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County *A.A. Co.*
 City or town *Marley*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Annie Louise**Tydings*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Thomas A. Tydings*6. (c) If alive, give age *61* years7. Birth date of deceased (mo. day. yr.) *February 6, 1887*8. AGE: Years *61* Months Days If less than one day hrs. min. 9. Birthplace *Maryland*
(Town, county, and state)10. Usual occupation *None*11. Industry or business *None*12. Name *James Kidwell*13. Birthplace *District of Columbia*14. Maiden name *Sarah Forty*15. Birthplace *Maryland*16. Informant *Thomas A. Tydings*Address *Marley*17. Burial *Burial* Date thereof *4/10/48*
(Burial, cremation, or removal. Which?)Cemetery or crematory *Cedar Hill*Location *Annapolis Blvd*18. Funeral director *John F. Denny Inc.*Address *711 Light St.*19. *4-10* Date rec'd by registrar *1948* A.W. Scherck Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *A.A. Co.*City or town *Marley*
(If outside city or town limits, write RURAL and give nearest town)Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH *April 7th* 1948 at 10⁴⁵ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 6* 1948 to *April 7th* 1948 and that I last saw her alive on *April 6th* 1948Immediate cause of death *Cerebral Hemorrhage*Due to *Chronic Intestinal Obstruction*Due to *Chronic Endocarditis* } unknownOther conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE *J. H. Geysman M.D.* M.D. or other Address *100 Prince St.* Date signed *4/9/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03547

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County.....

City or town.....

Towson Arundel

Tracy's Landing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Thomas Edward Wallace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

C

Married

6. (b) Name of husband or wife.....

Florence Wallace

7. Birth date of

deceased (mo., day, yr.)

Oct 9, 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71

5

25

hrs.

min.

9. Birthplace.....

Tracy's Landing, A.A Co., Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal (which?).....

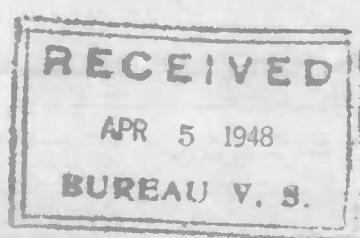
Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. It is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03548

93d

28

Reg. Dia. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Anne Arundel County

Crownsville City or town

(If outside city or town limits, write RURAL and give nearest town)

9 yrs. 6 mos.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution?

9 yrs. 6 mos.

3. (a) FULL NAME

MARY ANNA ELIZABETH WILLIAMS

3. (b) Social Security Number

4. Sex

female

5. Color or race

negro

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

578

1891?

8. AGE:

Years
57?

Months

Days

If less than one day

hrs. min.

9. Birthplace

Frederick, Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name Hedson Ronsberg (deceased)

13. Birthplace unknown

14. Maiden name

Katie Williams (deceased)

15. Birthplace

unknown

16. Informant

Hospital Records

Address

Crownsville, Md.

17. Burial

Date thereof

4/27/48
(month) / (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery

Hospital

Location

Crownsville Md

18. Funeral director

Supt.

Address

Crownsville Md

19. Date rec'd by registrar

19

4/17/48

E. J. Joyce Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Frederick

City or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No. 426 Klinehart Alley

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 14

19

48

at 3:00 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

October

19

to April 14

19

48

and that I last saw her alive on April 14

19

48

Immediate cause of death Chronic Myocarditis

Known to us since

DURATION
9/28/38

Due to

Due to

Other conditions Psychosis and Mental Deficiency

known to us since

9/28/38

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jacob M. Marguerite, M.D.

M. D. or other

Address Crownsville, Md.

Date signed 4/14/48

